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ABSTRACT

Increasingly, Mental health professionals are turning for support and assistance in their work to citizens in the community. Consequently, the roles of citizen groups as participants and collaborators have taken on increased significance. These citizens are asking, "How much influence will they be allowed to exert in planning and implementing community mental health programs?" This paper illustrates the issue by discussing the experiences and problems faced by legally authorized citizen area boards in Massachusetts since 1967 when a law reorganizing the Department of Mental Health went into effect to provide more effective comprehensive mental health and mental retardation services across the state. The composition of the boards is described and legal provisions concerning their duties and powers are elaborated. The findings of a study conducted by the Department of Mental Health to ascertain area board involvement and concomitant problems and goals are discussed. Questions raised by the survey relate to: (1) power; (2) leadership; (3) community control; (4) money; (5) intergroup reconciliation; (6) planning; and (7) philosophies of service delivery versus community and social change. A discussion about the future of citizen area boards in Massachusetts concludes the paper. (TL)

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CITIZEN PARTICIPATION AND INFLUENCE IN COMPREHENSIVE MENTAL HEALTH/RETARDATION PROGRAMS: REAL OR APPARENT?

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In an increasing number of States, mental health professionals are turning for support to citizens in the community who serve as indigenous non-professionals, as resource persons, as advisory mental health board members, as trustees of mental institutions, and as members of local mental health and retardation area boards and associations. At the same time, in return for their support, the citizens are demanding more voice and more community control over mental health and retardation activities and directions in their community. In some extreme instances this has led to a violent confrontation between the mental health "establishment" and indigenous non-professional workers and local citizens - such as the Lincoln Hospital protest against the Albert Einstein College of Medicine administrators in March 1969. For the most part, however, the confrontation has been less dramatic but, none the less, persistent, especially as the community mental health philosophy has brought the mental health professionals into more direct contact with local citizen groups, and as this trend has emphasized joint professional and community responsibility for the prevention and care of emotionally and mentally disabled persons.

Citizens, historically, have had considerable influence on mental health and retardation movements and services through dissemination of information, political lobbying, and education. In the mid 1800's Dorothea Dix, through her tireless campaign on behalf of the mentally ill, brought about the establishment of numerous State hospitals throughout the nation. Her intentions were good although we ended up with human warehouses for society's cast offs instead of the humane care and treatment of the mentally ill which she envisaged. In the early 1900's, due largely to the efforts of Clifford Beers, the child guidance movement in America was initiated, leading to the formation of hundreds of local and state mental health associations across the country. During the 40's and 50's

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parents of retarded children began to form chapters of the Association for Retarded Children in order to exert more influence in their lobbying for educational and rehabilitation programs for the mentally retarded. In recent years, we have witnessed the appearance of numerous associations which have been organized to obtain more and better programs for mentally ill children, the cerebral palsied, alcoholics, drug dependent persons, children with birth defects, etc.

Some citizen groups have had less impact in altering the course of mental health and retardation care - I refer to trustees of institutions (generally political appointments), to advisory boards (whose influence has waxed and waned over the years), and to ad hoc committees formed to investigate a "crisis" in an institution or to respond to a current political crusade.

In the past few years, as states have reorganized their mental health and retardation programs in order to conform to the trend toward community mental health philosophy and practice, and (not insignificantly) in order to become eligible for those federal grants available for mental health and retardation construction and staffing, the role of citizen groups as participants and collaborators in this process of change has taken on increased significance. Whereas, formerly, citizen groups were content to serve as volunteers, fund raisers, publicizers, advisors, and lobbyists for mental health and retardation professionals, they now are seeking "a piece of the action". As citizen groups exert pressures to exercise more voice regarding local programs, expenditures of money, hiring of personnel, and setting of priorities, mental health and retardation administrators at the state, regional, and local levels are being faced with the "moment of truth". In the community mental health movement much emphasis has been placed upon the role and participation of indigenous citizens as workers, planners, and colleagues. Now, many citizens who have responded to this promise wish to know how much influence they will be allowed to exert in the planning and implementation phases of community mental health programs. In short, they wish succinct and unambigous answers to the key question: "Is our participation and influence in comprehensive mental health and retardation programs (to be) real or apparent?"

This issue can be illustrated by discussing the experiences and problems faced by citizen groups in Massachusetts since 1967 when a law reorganizing the Department of Mental Health went into effect to provide more effective comprehensive mental health and mental retardation services in communities across the State.

Under the provisions of the law, 37 mental health and mental retardation areas were formed (now 39) and each area was authorized to establish a 21 citizen area board. But, the same law also stipulated that the area board "shall be an agency of the Commonwealth and shall serve (without compensation) in the Department (of Mental Health)". At the very least, this compromises the board's function as a "watchdog", as a critical observer, and as a "devil's advocate". The law further states: "The area board . . . shall be appointed by the Commissioner". Although four members must be selected from the local mental health association and four from the local association for retarded children the Commissioner of mental health has the final approval in their selection and may reject any or all of the nominees. The law does direct the Commissioner to include at least one member from each city within the area and, if practicable, from each town. Geographical representation in the membership of the board is encouraged but no mandate other than the provision of mental health and retardation representatives, is given to include representatives of such interest groups as the elderly, the indigent, the alcoholic, the addict, labor, business, clergy, law enforcement, education, etc. In all fairness, it should be stressed that, to date, it has been the practice of the Commissioner to approve all nominees put forth by the local citizens for the area boards subject only to the explicit restrictions placed upon him by the law. The citizens, however, justifiably point out that a less progressive and liberal Commissioner in the future may not be inclined to follow suit. They would prefer to have their prerogatives written into law rather than dispensed to them by a mental health administrator, no matter how generous or benign he may be.

But, to continue with the provisions of the law regarding the composition of the area board: up to one-third (8) may be employees of the Commonwealth excluding the Department of Mental Health. A member serves a term of three years and may be

reappointed for one additional three-year term at the Commissioner's discretion. The area board elects from its members a president, and such other officers as it deems appropriate. While the area board may adopt rules and procedures these must be submitted to the Commissioner for his approval. Thus, the area board in its formation, composition, replacement, and establishment of rules and regulations is dependent upon the Commissioner's approval.

Next, let us examine what the law says about its duties and powers. The area board shall:

1) Act as the representative of the citizens of the area;
2) Advise regarding local needs and resources in the development of comprehensive mental health and retardation services;
3) Advise in the recruitment and selection of the area director and associate area director to be appointed by the commissioner;
4) Review and approve the annual plan and review and make recommendations concerning the annual budget for the comprehensive mental health and retardation services of the area;
5) Review arrangements and contracts for (non-State) programs and services which are part of the program of the area;
6) Consult with the Commissioner in personnel recruitment and appointment policies, in the establishment of program priorities for the area, in admission policies for all facilities and services, and in policies regarding relationships with other agencies and organizations;
7) Receive and administer gifts or bequests of personal property or funds in trust or grants of land made to its use in trust;
8) Receive funds under contracts or other agreements from community sources including municipalities for the rendering of services (Section 23, Item i).

Notice, that with two exceptions (i.e.: acting as representatives of the area and approving the annual plan for the area), the area board is empowered only to "advise", "review", "make recommendations", and "consult" with the Commissioner regarding area needs and programs, appointments of professional personnel, the area budgets, and contractual arrangements with non-State agencies. While the area board can accept and

administer gifts and funds received in trust, it can only receive but not administer (according to the Department's legal counsel) monies received from cities and towns wishing to support area wide mental health and/or mental retardation services and programs. These monies must be turned over to the Commonwealth's general fund. This last restriction is particularly galling to area board members who are thus deprived of any realistic source of funds to contract out for local services or to finance new programs. An amendment permitting area boards to expend as well as to receive municipal funds was recently introduced in the legislature but was defeated. The message thus transmitted by the legislators to the area board is clear: you may advise, review, and consult but you may not have the authority to spend money to develop programs or buy services (except from proceeds from gifts received in trust).

In order to ascertain the involvement of the citizen groups in the area mental health and mental retardation programs, the Department of Mental Health conducted a study of the areas' problems and goals, and factors affecting their development. The survey found that most of the area boards were actively involved in a variety of projects including participation in site selection, construction, and staffing requests for comprehensive centers; letters and phone calls to legislators regarding area budgets and favored mental health/retardation legislation; surveys and brochures regarding mental health and mental retardation area programs; the initiation of a telephone referral center for drug problems and a "listening ear" service for troubled teenagers; sponsorship of lecture series on drugs, gerontology, community mental health, and mental retardation. Thus, with some notable exceptions, most of the area boards assigned to themselves the responsibility for one or more action-oriented projects involving their area. Some of these projects were initiated at the requests of the professional advisors; many, however, came out of discussions of the board members themselves.

When asked to define the goals of the area boards, the area board members responded generally in terms of expanding psychiatric services to meet existing community problems. Only a few envisaged the citizens of the area or non-professionals as playing a significant participatory role in new programs or in community leadership (these were mostly parents of retarded children).

At the time of the survey, the area boards were undergoing what has been termed a "crisis of expectation" - that is, they were beginning to understand the complexities of the State's political and bureaucratic organization and to wonder whether their original high hopes as change agents would be realized. Their major concern centered about their ambiguous authority expressed in terms of lack of formal power, lack of an operating budget, lack of a leadership role, and the complexities of mental health issues. Interestingly, area boards members were divided over the issue of increased formal powers, especially the need for controls over area budgets or programs. Some were working actively for changes in the law that would invest more formal power in the area boards, others were unsure what the power of the boards should be and were deferring decisions until they had a clearer idea of their roles, still others felt that area boards should remain advisory and focus on area and regional planning rather than assuming control of specific facilities and programs within the area. There was much more agreement about the need for an operating budget for the area boards and for clarification of their legal authority to expend money for programs and services the source of such funds was also a matter of concern.

The meaningful activities of many area boards was due in large measure to some form of professional leadership ("professional" in this context refers to a person whose career - be it social service, psychiatry, psychology, clergy, etc. - involves a substantial investment of time and knowledge in mental health - related problems or behavioral science issues). Generally, the professionals became officers or members of the area board or served as chairman of action or service committees. Where these professionals were lacking, the area board often turned to the area director, regional administrator, or local university for help and guidance. It seems that, when confronted by complex issues, the layman frequently looks to the professional or "expert" for simple answers. The trouble is that these complex issues are poorly understood by professionals as well. The two major mental health issues raised by the area boards were, 1) the nature of their relationships with community agencies (e.g. schools, police, social service agencies, church groups, mental health and retardation associations, welfare agencies, etc.), and 2) the relative emphasis on provision of needed mental health and retardation programs and services versus the reliance on prevention and

consultation to caregivers in the community as the major focus. With respect to the first issue, there is distressing evidence of dissention and competition between long established mental health and retardation associations, boards of trustees of hospitals, social agencies, schools, Red Feather agencies, political groups, etc., and the newly emerging area boards entrusted with an area-wide mandate in the broad behavioral science field. It is not clear at present how the current fears and antagonisms among these diverse citizen groups will eventually be resolved. With respect to the latter issue of service versus prevention, a meaningful balance between these two concepts will have to be struck on a local level primarily by local citizens rather than by the professionals. In either event, the issue is not either autocratic control of area programs by mental health and retardation professionals, or complete community control of area-wide budgets and services but, rather, a reconciliation between the professional's desire for policy and standard setting and the community's need for local control of programs.

The survey poses many knotty questions which must be examined if citizen groups are to play a meaningful role in the development of comprehensive mental health and retardation programs. They relate to power, to leadership, to community control, to money, to intergroup reconciliation, to planning, and to philosophies of service delivery versus community and social change. Are local lay citizens capable of taking over the major direction of local mental health and retardation programs or do they need the hand of the professional at the helm? Are the professionals capable of relinquishing major control of program management to citizen groups or are they fearful that the ship will founder without their knowledge and experience? Do the local citizens really know what their community needs are or do they respond impulsively and erratically to day to day community demands? Have the professionals shown by the past experience of the last two decades that they are basically concerned with the impoverished, the alcoholic, the retarded, the geriatric, or more than a minority of neurotic and psychotic individuals in our society? Before answers can be sought, these and many other questions must be asked.

What is the future for citizen area boards in Massachusetts? It would be impossible to legislate or order area boards into a universal role. Roles will, by necessity, vary from

area to area depending upon the composition of the board, the local needs, and willingness of the community to accept changes. Varying roles throughout the 39 areas in the State are in fact becoming defined. They will be gradually modified as experience accumulates and local conditions warrant. Second, the realities of political life inevitably slow up the process of change and inhibit proposed solutions from being enacted too quickly. Yet, we have witnessed within the short span of three years several accomplishments by a number of area boards. Many have made their wishes known clearly to their area directors, regional administrators, and even the commissioner. (It is difficult for the mental health professional, even if he disagrees with their opinions, to ignore them completely.) The area boards have conducted public hearings, heard from local individuals and groups regarding local problems and issues, and, in many cases, have embarked upon projects designed to meet acute local needs. In one area, within a period of two months, an area board contracted for a halfway house for alcoholics, secured a special class in a local public school for severely disturbed adolescents, and worked actively with the area director to obtain support for a construction grant to develop a comprehensive community mental health and retardation center.

Area boards, because they legally have only advisory powers, have been criticized by some as being impotent, or worse, established as part of a plot to create the illusion of citizen influence in mental health and retardation programs. We have observed, in fact, that while lacking legal power in certain respects, the 39 area boards, comprising a total of 819 citizens, have had considerable success during the past three years in influencing the State's governmental bodies and in getting the attentive ear of the mental health and retardation professionals in the Department of Mental Health. When the area boards have spoken, the professionals and the legislators have listened closely. The commissioner has scheduled a three-day conference to be held in June to which representatives of each area board have been invited to discuss their accomplishments, their problems, and their goals with administrators from the Department. Among the issues which will be discussed at this meeting are the kind of roles the area boards can and should work toward and the kind of efforts that have to be made in order to further area board effectiveness. Some possible

roles in which an area board may serve are 1) as a catalyst stimulating programs and interest by gathering support for an idea or project, 2) as a lobbyist mobilizing votes of legislators or influencing key persons or groups in the community, 3) as an advisor and overseer becoming directly involved in program implementation, and/or 4) as a planning board initiating new programs and serving as a link between the mental health establishment and the community. The last suggestion, while probably most relevant, requires a degree of sophistication and understanding. I believe that it is the responsibility of the mental health and retardation professionals (through the Department of Mental Health, special university seminars, and local inservice training programs) to impart this knowledge and understanding to them. The process of change from complete professional control over the direction of area programs to increased community control is occurring inexorably whether we may personally wish it or not. Local citizens are making their voices heard - if the professionals ignore them it is at their peril. Rather, it is incumbent upon the professionals to provide the citizens with the widest range of information so that they may participate intelligently as equals in the decision-making process, although it is my belief that the ultimate authority should rest in the hands of the professionals.

The extent of further participation of citizens on the area board in Massachusetts will depend on numerous factors such as changes in the existing law, clarification over the overlapping roles and functions between area boards and local special interest citizen groups, better channels of communication between citizens and professionals, and mutual respect for each other's contribution to the betterment of the quality of life for the residents of the community. Citizens can contribute significantly to the realization of meaningful community services and programs if we as professionals will but let them.

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